FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037358

Facility Name: BRIDGEVIEW HEALTH CARE CENTER

Address: 8100 SOUTH HARLEM AVENUE (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3780344

Date of Initial License for Current Owners: 10/02/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,617	5,260	5,691	22,568	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	20,553	6,327	525	27,405	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,170	11,587	6,216	49,973	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.78%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/02/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/02/1991 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 4,892

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	213,365	34,981	6,572	254,918		254,918		254,918			1
2	Food Purchase		239,207		239,207	(36,683)	202,524	(2,175)	200,349			2
3	Housekeeping	25,362	27,390		52,752		52,752		52,752			3
4	Laundry	9,358	22,554	94,888	126,800		126,800		126,800			4
5	Heat and Other Utilities			107,981	107,981		107,981	1,333	109,314			5
6	Maintenance	67,559	23,023	161,865	252,447		252,447	11,249	263,696			6
7	Other (specify):*			7,835	7,835		7,835	725	8,560			7
8	**TOTAL General Services**	315,644	347,155	379,141	1,041,940	(36,683)	1,005,257	11,132	1,016,389			8
	B. Health Care and Programs											
9	Medical Director			2,100	2,100		2,100		2,100			9
10	Nursing and Medical Records	2,003,923	78,030	190,463	2,272,416		2,272,416	(4,425)	2,267,991			10
10a	Therapy		1,918	354	2,272		2,272		2,272			10a
11	Activities	250,250	16,068	2,366	268,684		268,684		268,684			11
12	Social Services			1,447	1,447		1,447		1,447			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,254,173	96,016	196,730	2,546,919		2,546,919	(4,425)	2,542,494			16
	C. General Administration											
17	Administrative	93,278		280,356	373,634		373,634	(166,269)	207,365			17
18	Directors Fees											18
19	Professional Services			78,809	78,809		78,809	2,774	81,583			19
20	Dues, Fees, Subscriptions & Promotions			75,242	75,242		75,242	(62,692)	12,550			20
21	Clerical & General Office Expenses	219,582	30,925	215,104	465,611		465,611	(125,073)	340,538			21
22	Employee Benefits & Payroll Taxes			446,414	446,414	36,683	483,097		483,097			22
23	Inservice Training & Education			3,043	3,043		3,043		3,043			23
24	Travel and Seminar							111	111			24
25	Other Admin. Staff Transportation			5,950	5,950		5,950	1,775	7,725			25
26	Insurance-Prop.Liab.Malpractice			128,258	128,258		128,258	2,253	130,511			26
27	Other (specify):*			5,132	5,132		5,132	25,756	30,888			27
28	**TOTAL General Administration**	312,860	30,925	1,238,308	1,582,093	36,683	1,618,776	(321,365)	1,297,411			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,882,677	474,096	1,814,179	5,170,952		5,170,952	(314,658)	4,856,294			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BRIDGEVIEW HEALTH CARE CENTER #0037358 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,252	
	REPAIRS & MAINTENANCE		320	
			0	6,572
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,561	
	CONTRACTED LAUNDRY SERV		92,327	94,888
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		53,448	
	ELECTRICITY		28,182	
	WATER		26,351	
	CABLE TV - LOBBY		0	
			0	107,981
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,897	
	PAINTING & DECORATING		467	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		3,395	
	ELEVATOR MAINTENANCE & REPAIR		6,768	
	OUTSIDE LABOR		142,298	
	EXTERMINATING SERVICE		4,040	
	FIRE SERVICE		0	
			0	
			0	
			0	161,865
7	**OTHER**			
	SCAVENGER		7,835	
	SECURITY SERVICE		0	7,835
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,100	2,100

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	185,787	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,250	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	426	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	190,463
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		76	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	278	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	354
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,366	
			0	2,366
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,447	
			0	1,447
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER #0037358 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	280,356	280,356
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,236	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	74,573	
			0	78,809
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	60,221	
	EMPLOYEE WANT ADS	XIX F	948	
	CONTRIBUTIONS	VI 20 XIX F	576	
	DUES & SUBSCRIPTIONS	XIX F	7,092	
	LICENSES & PERMITS	XIX F	2,473	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,912	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,020	75,242
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		169	
	EQUIPMENT REPAIR & MAINTENANCE		15,152	
	OUTSIDE CLERICAL SERVICES		187,200	
	PENALTIES / OVERDRAFT CHARGES	VI 18	60	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,523	
	MESSENGER SERVICE		0	
			0	215,104

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	214,385	
	UNEMPLOYMENT COMPENSATION	XIX D	47,171	
	WORKERS COMPENSATION INSURANCI	XIX D	77,052	
	HOSPITALIZATION INSURANCE	XIX D	93,855	
	EMPLOYEE BENEFITS - OTHER	XIX D	13,951	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	446,414
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,043	3,043
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,950	5,950
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		128,258	128,258
27	**OTHER**			
	BAD DEBTS	VI 24	5,132	
				5,132

GRAND TOTAL COLUMN 3 OTHER 1,814,179

BRIDGEVIEW HEALTH CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	239,207	PATIENT MEALS	149919
LESS SALES TAX	(1,381)	ADD EMPLOYEE MEALS	27375
NET FOOD	237,826	TOTAL MEALS/YEAR	177294
TOTAL PATIENT CENSUS	49,973	NET FOOD	237826
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	177294
TOTAL PATIENT MEALS	149919	COST PER MEAL	1.34
		TIME EMPLOYEE MEALS	27375
ADD # EMPLOYEE MEALS/DAY	75		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	36683
TOTAL EMPLOYEE MEALS	27375		

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER #0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			39,841	39,841		39,841	155,234	195,075			30
31	Amortization of Pre-Op. & Org.							4,939	4,939			31
32	Interest			25,434	25,434		25,434	389,929	415,363			32
33	Real Estate Taxes			196,467	196,467		196,467	3,569	200,036			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			5,730	5,730		5,730	5,956	11,686			35
36	Other (specify):*											36
37	TOTAL Ownership			756,712	756,712		756,712	70,387	827,099			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,489	317,844	453,333		453,333	(4,712)	448,621			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		135,489	397,779	533,268		533,268	(4,712)	528,556			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,882,677	609,585	2,968,670	6,460,932		6,460,932	(248,983)	6,211,949			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(33,159)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(794)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,381)	2		13
14	Non-Care Related Interest	(58)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(60)	21		18
19	Entertainment		20		19
20	Contributions	(3,488)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,132)	27		24
25	Fund Raising, Advertising and Promotional	(60,221)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (104,293)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(144,690)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (144,690)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (248,983)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BRIDGEVIEW HEALTH CARE CENTER

ID# 0037358

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	PAINTING & DECORATING			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,175)	0	0	0	0	0	0	0	0	0	0	(2,175)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,333	0	0	0	0	0	0	0	0	1,333	5
6	Maintenance	0	0	3,794	7,455	0	0	0	0	0	0	0	11,249	6
7	Other (specify):*	0	0	0	0	725	0	0	0	0	0	0	725	7
8	**TOTAL General Services**	(2,175)	0	5,127	7,455	725	0	0	0	0	0	0	11,132	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(4,425)	0	0	0	0	0	(4,425)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(4,425)	0	0	0	0	0	(4,425)	16
	C. General Administration													
17	Administrative	0	(280,356)	0	114,087	0	0	0	0	0	0	0	(166,269)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	2,774	0	0	0	0	0	0	0	0	2,774	19
20	Fees, Subscriptions & Promotions	(63,709)	0	1,017	0	0	0	0	0	0	0	0	(62,692)	20
21	Clerical & General Office Expenses	(60)	(187,200)	53,983	8,204	0	0	0	0	0	0	0	(125,073)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	111	0	0	0	0	0	0	0	0	111	24
25	Other Admin. Staff Transportation	0	0	1,775	0	0	0	0	0	0	0	0	1,775	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,253	0	0	0	0	0	0	0	0	2,253	26
27	Other (specify):*	(5,132)	0	11,148	0	19,740	0	0	0	0	0	0	25,756	27
28	**TOTAL General Administration**	(68,901)	(467,556)	73,061	122,291	19,740	0	0	0	0	0	0	(321,365)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,076)	(467,556)	78,188	129,746	20,465	(4,425)	0	0	0	0	0	(314,658)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(33,159)	185,412	2,981	0	0	0	0	0	0	0	0	155,234	30
31	Amortization of Pre-Op. & Org.	0	4,939	0	0	0	0	0	0	0	0	0	4,939	31
32	Interest	(58)	386,654	3,333	0	0	0	0	0	0	0	0	389,929	32
33	Real Estate Taxes	0	0	3,569	0	0	0	0	0	0	0	0	3,569	33
34	Rent-Facility & Grounds	0	(489,240)	0	0	0	0	0	0	0	0	0	(489,240)	34
35	Rent-Equipment & Vehicles	0	0	5,956	0	0	0	0	0	0	0	0	5,956	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(33,217)	87,765	15,839	0	0	0	0	0	0	0	0	70,387	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(4,712)	0	0	0	0	0	(4,712)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(4,712)	0	0	0	0	0	(4,712)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(104,293)	(379,791)	94,027	129,746	20,465	(9,137)	0	0	0	0	0	(248,983)	45

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 280,356	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (280,356)	1
2	V	21	BOOKKEEPING SERVICES	187,200	" "			(187,200)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	489,240	BRIDGEVIEW ASSOCIATES LLC			(489,240)	7
8	V	30	DEPRECIATION		" "		185,412	185,412	8
9	V	31	AMORTIZATION		" "		4,939	4,939	9
10	V	32	INTEREST		" "		386,654	386,654	10
11	V								11
12	V								12
13	V								13
14	Total			$ 956,796			$ 577,005	$ * (379,791)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 1,333	$ 1,333	15
16	V	6	REPAIR & MAINT.		" " "		3,794	3,794	16
17	V	19	PROFESSIONAL FEES		" " "		2,774	2,774	17
18	V	20	DUES AND SUBSCRIPTION		" " "		1,017	1,017	18
19	V	21	CLERICAL & GENERAL		" " "		53,983	53,983	19
20	V	24	SEMINARS AND TRAVEL		" " "		111	111	20
21	V	25	AUTO EXPENSE		" " "		1,775	1,775	21
22	V	26	INSURANCE		" " "		2,253	2,253	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "		11,148	11,148	23
24	V	30	DEPRECIATION		" " "		2,981	2,981	24
25	V	32	INTEREST		" " "		3,333	3,333	25
26	V	33	REAL ESTATE TAXES		" " "		3,569	3,569	26
27	V	35	EQUIPMENT RENTAL		" " "		5,956	5,956	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 94,027	$ * 94,027	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 7,455	$ 7,455	15
16	V	17	ADMIN. CMP. - M. MAUER		" " "		20,570	20,570	16
17	V	17	ADMIN. CMP. - M. AARON		" " "		22,992	22,992	17
18	V	17	ADMIN. CMP. - F. AARON		" " "		14,122	14,122	18
19	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "				19
20	V	17	ADMIN. CMP. - S. KOPLIN		" " "				20
21	V	17	ADMIN. CMP. - D. MAGAFAS		" " "		14,162	14,162	21
22	V	17	ADMIN. CMP. - S. LEVY		" " "		19,148	19,148	22
23	V	17	ADMIN. CMP. - HOWARD ALTER		" " "				23
24	V	17	ADMIN. CMP. - NON-OWNER		" " "		23,093	23,093	24
25	V	21	CLERICAL. CMP. - S. AARON		" " "		8,204	8,204	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 129,746	$ * 129,746	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 725	$ 725	15
16	V	27	EMP.BEN. - M. MAUER		" " "		1,407	1,407	16
17	V	27	EMP. BEN. - M. AARON		" " "		1,830	1,830	17
18	V	27	EMP. BEN. - F. AARON		" " "		6,749	6,749	18
19	V	27	EMP. BEN. - S. GOLDSTEIN		" " "				19
20	V	27	EMP. BEN. - S. KOPLIN		" " "				20
21	V	27	EMP. BEN. - D. MAGAFAS		" " "		1,146	1,146	21
22	V	27	EMP. BEN. - S. LEVY		" " "		3,002	3,002	22
23	V	27	EMP. BEN. - H. ALTER		" " "				23
24	V	27	EMP. BEN. - NON-OWNER		" " "		3,789	3,789	24
25	V	27	EMP. BEN. - S. AARON		" " "		1,817	1,817	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 20,465	$ * 20,465	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	DYNAMIC REHAB CONSULTANTS LLC		$	$	15
16	V	19	PROFESSIONAL FEES		" " "				16
17	V	22	EMPLOYEE BENEFITS		" " "				17
18	V	39	ANCILLARY SERVICES		" " "				18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	15,176	LINCOLN MEDICAL SUPPLIES, INC.		10,751	(4,425)	21
22	V	39	ANCILLARY EXPENSE	16,159	" " "		11,447	(4,712)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 31,335			$ 22,198	$ * (9,137)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MARSHALL MAUER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 20,570	17-7	1
2	MAURY AARON		ADMINISTRATIVE					SALARY	22,992	17-7	2
3	SHARON AARON		CLERICAL					SALARY	8,204	21-7	3
4	FRED AARON		ADMINISTRATIVE					SALARY	14,122	17-7	4
5	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	14,162	17-7	5
6	DENNIS NEHMER		MAINTENANCE					SALARY	7,455	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 87,505		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	413,836	12	$ 11,039	$	49,973	$ 1,333	1
2	6	REPAIR & MAINT.	" "	413,836	12	31,419		49,973	3,794	2
3	19	PROFESSIONAL FEES	" "	413,836	12	22,969		49,973	2,774	3
4	20	DUES AND SUBSCRIPTION	" "	413,836	12	8,420		49,973	1,017	4
5	21	CLERICAL & GENERAL	" "	413,836	12	447,045	345,326	49,973	53,983	5
6	24	SEMINARS AND TRAVEL	" "	413,836	12	917		49,973	111	6
7	25	AUTO EXPENSE	" "	413,836	12	14,696		49,973	1,775	7
8	26	INSURANCE	" "	413,836	12	18,661		49,973	2,253	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	413,836	12	92,321		49,973	11,148	9
10	30	DEPRECIATION	" "	413,836	12	24,690		49,973	2,981	10
11	32	INTEREST	" "	413,836	12	27,602		49,973	3,333	11
12	33	REAL ESTATE TAXES	" "	413,836	12	29,555		49,973	3,569	12
13	35	EQUIPMENT RENTAL	" "	413,836	12	49,319		49,973	5,956	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 778,653	$ 345,326		$ 94,027	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	12	$ 55,120	$ 55,120	5	$ 7,455	1
2	17	ADMIN. CMP. - M. MAUER	" "	40	12	170,000	170,000	5	20,570	2
3	17	ADMIN. CMP. - M. AARON	" "	40	12	170,000	170,000	5	22,992	3
4	17	ADMIN. CMP. - F. AARON	" "	47	12	88,500	88,500	8	14,122	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	" "	45	12	24,000	24,000			5
6	17	ADMIN. CMP. - S. KOPLIN	" "	40	12	72,485	72,485			6
7	17	ADMIN. CMP. - D. MAGAFAS	" "	45	12	104,642	104,642	6	14,162	7
8	17	ADMIN. CMP. - S. LEVY	" "	45	12	158,233	158,233	5	19,148	8
9	17	ADMIN. CMP. - H. ALTER	" "	40	12	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	" "	45	12	170,636	170,636	6	23,093	10
11	21	CLERICAL. CMP. - S. AARON	" "	40	12	67,785	67,785	5	8,204	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,093,401	$ 1,093,401		$ 129,746	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	12	$ 5,362	$	5	$ 725	1
2	27	EMP.BEN. - M. MAUER	" "	40	12	11,631		5	1,407	2
3	27	EMP. BEN. - M. AARON	" "	40	12	13,532		5	1,830	3
4	27	EMP. BEN. - F. AARON	" "	47	12	42,295		8	6,749	4
5	27	EMP. BEN. - S. GOLDSTEIN	" "	45	12	33,649				5
6	27	EMP. BEN. - S. KOPLIN	" "	40	12	25,376				6
7	27	EMP. BEN. - D. MAGAFAS	" "	45	12	8,470		6	1,146	7
8	27	EMP. BEN. - S. LEVY	" "	45	12	24,807		5	3,002	8
9	27	EMP. BEN. - H. ALTER	" "	40	12	1,105				9
10	27	EMP. BEN. - NON-OWNER	" "	45	12	27,997		6	3,789	10
11	27	EMP. BEN. - S. AARON	" "	40	12	15,016		5	1,817	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 209,240	$		$ 20,465	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION							2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "							5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			10,751			10,751	9
10	39	ANCILLARY EXPENSE	" "			11,447			11,447	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 22,198	$		$ 22,198	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAMBRIDGE		X	MORTGAGE	$54,580.50	7/01	$ 5,722,000	$ 5,524,076			$ 386,654	1
2												2
3												3
4												4
5	WOODBRIDGE	X		WORKING CAPITAL								5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL							22,299	6
7			X	INSURANCE FINANCING							3,135	7
8	RELATED PARTY										3,333	8
9	TOTAL Facility Related				$54,580.50		$ 5,722,000	$ 5,524,076			$ 415,421	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,722,000	$ 5,524,076			$ 415,421	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 188,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 187,467	2
3. Under or (over) accrual (line 2 minus line 1).		$ (533)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 197,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 196,467	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	177,631	8
	2001	180,886	9
	2002	169,450	10
	2003	179,476	11
	2004	187,467	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIDGEVIEW HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037358

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-0000	NURSING HOME	$ 187,467.42	$ 187,467.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 187,467.42	$ 187,467.42

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,560 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 304,000	1
2					2
3	TOTALS			$ 304,000	3

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		1995		$ 5,092,000	$ 130,564	39	$ 130,564	$	$ 1,452,223	4
5					490,058	34,886			(34,886)		5
6											6
7											7
8	RELATED PARTY					1,373		1,530	157		8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		455	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715	181	15	181		2,572	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		37,827	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		648	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		2,407	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		329	14
15	CARPET INSTALL			1995	1,303	33	39	33		337	15
16	RAIL BUMPER			1995	917	24	39	24		241	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	137	39	137		1,310	17
18	PAINTING WORK			1996	8,400	215	39	215		2,016	18
19	WALL COVERING			1996	1,435	37	39	37		344	19
20	FRONT LOBBY/WINDOW, DOOR WORK			1997	2,509	64	39	64		544	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		567	21
22	CONDENCING UNIT			1999	3,824	98	39	98		652	22
23	DRAPES			1999	5,369	138	39	138		882	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		1,419	24
25	DOOR WORK			1999	10,490	269	39	269		1,706	25
26	KITCHEN CABINETS			1999	5,832	149	39	149		968	26
27	TILES			2000	8,855	322	27.5	322		1,746	27
28	ELEVATOR REPAIR			2000	4,240	153	27.5	153		744	28
29	ROD MAIN SEWER			2000	1,100	41	27.5	41		219	29
30	DRAPERIES			2001	2,118	303	7	303		1,947	30
31	RECEPTION DESK/DOOR			2002	9,534	347	27.5	347		1,041	31
32	FLOORING / BUMPER GUARDS			2002	11,198	407	27.5	407		1,222	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	1,530	27.5	1,530		4,372	33
34	WIRING, MOTOR			2002	9,224	336	27.5	336		1,008	34
35	HANDRAILS & GUARDS			2003	7,811	284	27.5	284		698	35
36	FENCES & CONCRETE			2003	4,023	134	15	268	134	2,481	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BOARDS	2003	$ 1,752	$ 64	27.5	$ 64	$	$ 1,880	37
38	COIL	2003	806	29	27.5	29		864	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		4,281	39
40	WINDOE TREATMENTS	2003	1,672	61	27.5	61		1,794	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		7,189	41
42	FLOOR COVERING	2004	888	32	27.5	32		47	42
43	CABINETS	2004	2,594	95	27.5	95		138	43
44	BOILER	2004	2,574	93	27.5	93		136	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		63	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		431	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		3,447	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	166	27.5	166		166	48
49	SECURITY MONITORS	2005	1,375	23	27.5	23		23	49
50	CARPET & VINYL	2005	21,130	352	27.5	352		352	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,932,667	$ 179,290		$ 144,695	$ (34,595)	$ 1,543,736	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 243,505	$ 16,308	$ 23,845	$ 7,537	10	$ 138,758	71
72	Current Year Purchases	55,331	11,066	2,766	(8,300)	10	2,766	72
73	Fully Depreciated Assets	73,396					73,396	73
74	RELATED PARTY		20,228	22,367	2,139			74
75	TOTALS	$ 372,232	$ 47,602	$ 48,978	$ 1,376		$ 214,920	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NURSING MAINT HOUSEK	1991 DODGE VAN	1991	$ 24,971	$	$	$	4	$ 24,971	76
77										77
78	RELATED PARTY				1,342	1,402	60			78
79										79
80	TOTALS			$ 24,971	$ 1,342	$ 1,402	$ 60		$ 24,971	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,633,870	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 228,234	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 195,075	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (33,159)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,783,627	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,265 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		ELGIN TOYOTA	$ 470.00	$ 389	17
18		AMERICAN EXPRESS		76	18
19					19
20					20
21	TOTAL		$ 470.00	$ 465	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 156,135	$		$ 156,135	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,848			11,848	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			149,861			149,861	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				101,326		101,326	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES,LAB.RADIOLOGY Other (specify): RENTALS	39-2					34,163		34,163	13
14	TOTAL			$		$ 317,844	$ 135,489		$ 453,333	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 414,463	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (44688)	911,776		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,706		6
7	Other Prepaid Expenses	18,225		7
8	Accounts Receivable (owners or related parties)	3,820		8
9	Other(specify): Real Estate Tax Escrow	100,482		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,519,472	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	350,609		15
16	Equipment, at Historical Cost	372,232		16
17	Accumulated Depreciation (book methods)	(385,290)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	527,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 865,051	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,384,523	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 630,393	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	327,250		29
30	Accrued Salaries Payable	329,840		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,139		31
32	Accrued Real Estate Taxes(Sch.IX-B)	197,000		32
33	Accrued Interest Payable	2,302		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,508,924	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,508,924	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 875,599	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,384,523	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 381,550	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 381,550	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	570,049	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(76,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 494,049	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 875,599	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	1 Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,829,908	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,829,908	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	200,221	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 200,221	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	58	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 58	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT EARNED	794	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 794	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,030,981	30

	2 Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,041,940	31
32	Health Care	2,546,919	32
33	General Administration	1,582,093	33
	B. Capital Expense		
34	Ownership	756,712	34
	C. Ancillary Expense		
35	Special Cost Centers	453,333	35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,460,932	40
41	**Income before Income Taxes (line 30 minus line 40)****	570,049	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 570,049	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,906	2,182	$ 71,445	$ 32.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,635	7,679	210,148	27.37	3
4	Licensed Practical Nurses	28,310	32,028	718,283	22.43	4
5	CNAs & Orderlies	89,617	100,708	967,373	9.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,906	2,131	39,639	18.60	9
10	Activity Assistants	17,870	20,254	210,611	10.40	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,787	3,279	49,884	15.21	13
14	Head Cook	4,225	4,592	40,716	8.87	14
15	Cook Helpers/Assistants	13,851	15,000	122,765	8.18	15
16	Dishwashers					16
17	Maintenance Workers	3,483	3,810	67,559	17.73	17
18	Housekeepers	2,843	3,119	25,362	8.13	18
19	Laundry	1,146	1,151	9,358	8.13	19
20	Administrator	2,042	2,371	93,278	39.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,605	10,144	219,582	21.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,838	2,104	36,674	17.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,064	210,552	$ 2,882,677 *	$ 13.69	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,252	1-3	35
36	Medical Director		2,100	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		4,250	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		278	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	59	2,366	11-3	44
45	Social Service Consultant	28	1,447	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	87	$ 16,693		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,220	$ 97,648	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	3,661	88,139	10-3	52
53	TOTAL (lines 50 - 52)	5,881	$ 185,787		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMIN		$ 93,278
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,278

B. Administrative - Other

Description	Amount
	$ 280,356
TOTAL (agree to Schedule V, line 17, col. 3)	$ 280,356
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		78,809
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 78,809

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,052
Unemployment Compensation Insurance	47,171
FICA Taxes	214,385
Employee Health Insurance	93,855
Employee Meals	36,683
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	13,951
TOTAL (agree to Schedule V, line 22, col.8)	$ 483,097

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	948
Health Care Worker Background Check	1,020
(Indicate # of checks performed 5)	
MARKETING/ADV/PROMO	60,221
TRUST/FRANCHISE/CONTRIB/ETC	3,488
LICENSES & PERMITS	2,473
DUES & SUBSCRIPTIONS	7,092
MGMT CO ALLOCATION	1,017
TRUST/FRANCHISE/CONTRIB/ETC	(3,488)
Less: Public Relations Expense	(0)
Non-allowable advertising	(60,221)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,550

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	111
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 111

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $5483**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,083** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **79,935**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **36,683** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees